STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445130	A. BUILDING _____ B. WING _____	C 09/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, SPARTA	34 GRACEY ST SPARTA, TN 38583

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to ensure staff provided urinary catheter care according to facility policy for one (#2) of five residents reviewed. The findings included: Resident #2 was admitted to the facility on August 5, 2010, with diagnoses to include Congestive Heart Failure, Atrial Fibrillation, Atherosclerotic Cardiovascular Disease, Chronic Obstructive Pulmonary Disease, Hypertension, Diabetes Mellitus, Obstructive Sleep Apnea, Prostate Cancer Status Post Radiotherapy, Benign Prostatic Hypertrophy, Glaucoma, Cerebrovascular Accident, Coronary Artery Bypass Graft and CPAP (continuous positive air pressure breathing device). Review of the Minimum Data Set completed on August 10, 2010 revealed the resident had memory problems; required extensive assistance with transfers, bathing, dressing, and grooming; was occasionally incontinent of bowel and bladder; was able to self-feed a low fat, low cholesterol No Added Salt Controlled Carbohydrate diet. Review of nursing notes dated August 7, 2010, at	F 281	This plan of correction is submitted as required under state and federal law. The submission of this plan does not constitute an admission on the part of NHC HealthCare Sparta as to the accuracy of the surveyor's findings not the conclusions drawn there from. The facility's submission of the plan of correction does not constitute an admission on the part of the facility that the findings are accurate, that the findings constitute a deficiency, or that the score and severity regarding any of the deficiencies cited are correctly applied. **F 281 – services provided meet professional standards** Resident # 2 was discharged from the facility on 8-7-2010 and did not return to the facility. On 10-12-11 all residents who have Foley catheters were reviewed by the Director of Nursing to verify that Output records were complete. Director of Nursing also visibly checked residents with Foley catheters to look for signs of leaking of urine or infections and compare that with documentation in the resident's record. On 10-11-11 Director of Nursing conducted in-service training for all licensed staff regarding Catheter Care procedures and requirement pertaining to recording outputs and proper documentation regarding signs of leaking of urine or infection.	10-12-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Ben Stapleton | Administrator | 10-13-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 5:00 a.m., revealed "...complained of not being able to void and pain. Voided in urinal earlier approx. (approximately) 200 cc amber urine. Penis and scrotum edematous;called...(named Nurse Practitioner). New order received. Foley cath (proper name of a urinary catheter) 16 French 10 ml (milliliter) bulb inserted. Pt. (patient) very uncomfortable during procedure. Had return of 50 cc (centiliters) dk (dark) amber urine". Continued review of nursing notes from the same day at 6:00 a.m., revealed "...spouse here. Made aware of new orders...". Further review of nursing notes as well as the medical record revealed no Intake and Output sheet for recording urine output nor was there any documentation in the nurses' notes regarding Foley catheter output. Review of nursing notes dated August 7, 2010, at 9:15 a.m., revealed "...Pt. complains of SOB (shortness of breath); O2 (oxygen) sat (saturation) 90%. Crackles present to (R) & (L) (right and left) lower lobes, crackles in (R) upper . Pt. put C-pap (device to assist with breathing) on. Discussed sending pt. to ER (emergency room). Spouse requests we take interventions at our facility before sending ... out. Penis still currently swollen and what appears to be blood leaking around catheter. .... (Named Nurse Practitioner) notified of pt. condition. Discussed concern of removing Foley put in D/T (due to) not able to void, may not be able to reinsert D/T swelling if unable to void...". Lasix (diurectic medication) 40 milligrams given per order. Continued review of nursing notes dated August 7, 2010, at 2:15 p.m., revealed "...lab results received and called to ... (named Nurse	F 281	**F 281 cont.** Director of Nursing or Unit Manager will monitor compliance of output being recorded and signs of infection through the quality assurance process. Output sheets will be monitored weekly x 8 weeks and Director of Nursing or Unit Manager will visibly check residents with Foley catheters to look for signs of leaking or urine or infections and compare that with documentation in the resident's record. Findings of the quality assurance monitor will be reported by the Director of Nursing to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse.	

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F 281	Continued From page 2	F 281		

Practitioner). New order to send pt. to ... (named hospital) for evaluation. Further review of nursing notes at 3:00 p.m., revealed "... pt. left on stretcher with EMTs (emergency medical technicians) ..." Continued review of nursing notes revealed no documentation of the status of the earlier bleeding which was noted around the catheter.

Review of nursing notes from the Emergency Department (ED) dated August 7, 2010, at 4:12 p.m., revealed "...Pt, incontinent of small amt (amount) of light brown stool. Pt. cleaned. Bright red blood noted to meatus around Foley..." Continued review of ED nursing notes at 7:18 p.m., revealed "... Foley checked. Draining blood around meatus. Some small clots in tubing...". Continued review of notes at the same time revealed the resident received Lasix 40 mg (milligrams) intravenously. Further review of notes at 7:20 p.m., revealed "...urine now bloody with clots. ...(named physician) informed of necessity of CBI (continuous bladder irrigation) due to blood clots...". Continued review of notes at 8:45 p.m. revealed "... 22 - 3 way (size and type of urinary catheter) Foley inserted. CBI started. Penis swollen. 850 ml bloody urine with clots in old bag. Bloody urine return with new Foley, 30 ml bulb inflated...". Further review of notes at 9:45 p.m., revealed "...2650 ml pink urine from CBI bag emptied...".

Review of the hospital admission History and Physician dated August 8, 2010, revealed "...patient admitted due to frank blood per urethra upon changing of the foley (possibly from trauma due to repeated foley placement). The blood clots were numerous and the pt. was repeatedly

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F 281	Continued From page 3 obstructed, thus was not able to urinate...continuous urinary baldder irrigation was started and the bleeding/clots stopped." Review of the facility policy entitled "Catheter Care - Anchored" revealed "Observe area around catheter for any signs of leaking of urine or infection, such as redness, swelling...and Outputs should be kept on a any patient with a catheter and maintained until second voiding after Foley is discontinued". Interview with the Unit Manager on September 28, 2011, at 1:20 p.m., in the conference room, revealed the resident was voiding fine on admission. Continued interview revealed the patient's spouse wanted the patient to be treated at the facility first and was asked twice if ... wanted them to send the resident out.. During further interview, the Unit Manager confirmed there was no Intake and Output form in the resident's record. Continued interview with the Unit Manager confirmed there was no nursing documentation of the resident's output after the Foley catheter was inserted through discharge from the facility and there was also no ensuing documentation of the status of the resident's bleeding around the Foley catheter from 9:15 a.m. when it was initially noted through the resident's discharge from the facility at 3:00 p.m.	F 281		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315		

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F 315	Continued From page 4 catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure staff monitored a resident with a Foley catheter to prevent complications and failed to document appropriate information for one (#2) of five residents reviewed. The findings included: Resident #2 was admitted to the facility on August 5, 2010, with diagnoses to include Congestive Heart Failure, Atrial Fibrillation, Atherosclerotic Cardiovascular Disease, Chronic Obstructive Pulmonary Disease, Hypertension, Diabetes Mellitus, Obstructive Sleep Apnea, Prostate Cancer Status Post Radiotherapy, Benign Prostatic Hypertrophy, Glaucoma, Cerebrovascular Accident, Coronary Artery Bypass Graft, and CPAP (continuous positive air pressure breathing device). Review of the Minimum Data Set completed on August 10, 2010 revealed the resident had memory problems; required extensive assistance with transfers, bathing, dressing, and grooming; was occasionally incontinent of bowel and bladder; was able to self-feed a low fat, low cholesterol No Added Salt Controlled Carbohydrate diet.	F 315	**F315 – No Catheter, prevent UTI, Restore bladder** Resident # 2 was discharged from the facility on 8-7-2010 and did not return to the facility. On 10-12-11 all residents who have Foley catheters were reviewed by the Director of Nursing to verify that Output records were complete. Director of Nursing also visibly checked residents with Foley catheters to look for signs of leaking of urine or infections and compare that with documentation in the resident's record. On 10-11-11 Director of Nursing conducted in-service training for all licensed staff regarding Catheter Care procedures and requirement pertaining to recording outputs and proper documentation regarding signs of leaking of urine or infection. Director of Nursing or Unit Manager will monitor compliance of output being recorded and signs of infection through the quality assurance process. Output sheets will be monitored weekly x 8 weeks and Director of Nursing or Unit Manager will visibly check residents with Foley catheters to look for signs of leaking or urine or infections and compare that with documentation in the resident's record. Findings of the quality assurance monitor will be reported by the Director of Nursing to the Quality Assurance Committee which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Care Nurse.	10-12-11

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F 315	Continued From page 5 Review of nursing notes dated August 7, 2010, at 5:00 a.m., revealed "...complained of not being able to void and pain. Voided in urinal earlier approx. (approximately) 200 cc amber urine. Penis and scrotum edematous;called...(named Nurse Practitioner). New order received. Foley cath (proper name of a urinary catheter) 16 French 10 ml (milliliter) bulb inserted. Pt. (patient) very uncomfortable during procedure. Had return of 50 cc (centiliters) dk (dark) amber urine". Continued review of nursing notes from the same day at 6:00 a.m., revealed "...spouse here. Made aware of new orders...". Further review of nursing notes as well as the medical record revealed no Intake and Output sheet for recording urine output nor was there any documentation in the nurses' notes regarding Foley catheter output. Review of nursing notes dated August 7, 2010, at 9:15 a.m., revealed "...Pt. complains of SOB (shortness of breath); O2 (oxygen) sat (saturation) 90%. Crackles present to (R) & (L) (right and left) lower lobes, crackles in (R) upper . Pt. put C-PAP (device to assist with breathing) on. Discussed sending pt. to ER (emergency room). Spouse requests we take interventions at our facility before sending ... out. Penis still currently swollen and what appears to be blood leaking around catheter. .... (Named Nurse Practitioner) notified of pt. condition. Discussed concern of removing Foley put in D/T (due to) not able to void, may not be able to reinsert D/T swelling if unable to void...". Lasix (diuretic medication) 40 milligrams given per order. Continued review of nursing notes dated August	F 315		

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F 315	Continued From page 6 7, 2010, at 2:15 p.m., revealed "...lab results received and called to ... (named Nurse Practitioner). New order to send pt. to ... (named hospital) for evaluation. Further review of the nursing notes at 3:00 p.m., revealed "... pt. left on stretcher with EMTs (emergency medical technicians) ..." Continued review of nursing notes revealed no documentation of the status of the earlier bleeding which was noted around the catheter. Review of nursing notes from the Emergency Department (ED) dated August 7, 2010, at 4:12 p.m., revealed "...Pt, incontinent of small amt (amount) of light brown stool. Pt. cleaned. Bright red blood noted to meatus around Foley..." Continued review of ED nursing notes at 7:18 p.m., revealed "... Foley checked. Draining blood around meatus. Some small clots in tubing...". Continued review of notes at the same time revealed the resident received Lasix 40 mg (milligrams) intravenously. Further review of notes at 7:20 p.m., revealed "...urine now bloody with clots. ...(named physician) informed of necessity of CBI (continuous bladder irrigation) due to blood clots...". Continued review of notes at 8:45 p.m. revealed "... 22 - 3 way (size and type of urinary catheter) Foley inserted. CBI started. Penis swollen. 850 ml bloody urine with clots in old bag. Bloody urine return with new Foley, 30 ml bulb inflated...". Further review of notes at 9:45 p.m., revealed "...2650 ml pink urine from CBI bag emptied...". Review of the hospital admission History and Physician dated August 8, 2010, revealed "...patient admitted due to frank blood per urethra upon changing of the foley (possibly from trauma	F 315		

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F 315	Continued From page 7 due to repeated foley placement). The blood clots were numerous and the pt. was repeatedly obstructed, thus was not able to urinate...continuous urinary baldder irrigation was started and the bleeding/clots stopped." Review of the facility policy entitled "Catheter Care - Anchored" revealed "Observe area around catheter for any signs of leaking or urine or infection, such as redness, swelling...and "Outputs should be kept on a any patient with a catheter and maintained until second voiding after Foley is discontinued". Interview with the Unit Manager on September 28, 2011, at 1:20 p.m., in the conference room, revealed the resident was voiding fine on admission. Continued interview revealed the patient's spouse wanted the patient to be treated at the facility first and was asked twice if ... wanted them to send the resident out.. During further interview, the Unit Manager confirmed there was no Intake and Output form in the resident's record. Continued interview with the Unit Manager confirmed there was no nursing documentation of the resident's output after the Foley catheter was inserted through discharge from the facility and there was also no ensuing documentation of the status of the resident's bleeding around the Foley catheter from 9:15 a.m. when it was initially noted through the resident's discharge from the facility at 3:00 p.m.	F 315		